are completely damaged where others have been left with endangered to work in. The damaged infrastructure has left with inability to store essential drugs and vaccines. The cost of building new health care facilities is expected to reach billions of dollars. The cost required for the acute trauma is estimated very high. As homeless people are living in improper shelter, they have been presenting with other health related problems. For the short term relief, disaster management team should be formed in major government hospitals and medical colleges taking help of army and police health care personnel. Immediate enrolment of medical officers at the level of primary health centers should be done. A blend with major government and non-government organizations like International Red Cross, United Nations Organization, World Health Organization, USAID etc. should be made to meet the health care equipment, trained manpower and all other expenses. For the long term relief, trauma centers should be established in regional levels. As most of the remote villages even don't have primary health centers, the health and sub health posts should be upgraded to meet the demands. Health posts and sub health posts should engage at least medical officers backed up by supportive staffs and basic investigations.

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MARKET ACCESS FOR PHARMACEUTICALS IN EUROPE: FUTURE PERSPECTIVES

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BACKGROUND: Market access for pharmaceuticals is evolving in a fast-changing environment : (1)Pressure of European Union (EU) Member States (MS) on health insurance budgets; (2) Dramatic technological advances; targeting new biological pathways, advanced therapy medicinal products, personalized medicines, expansion of digital medicine; (3) Initiatives from regulators and payers to develop synergies, e.g., collaborations between HTA agencies and multi-HTA/parallel early advice; (4) Increased payer risk-aversion and increasing products with limited information at launch; (5) Healthcare organisations moving towards integrated healthcare services (6) Ageing population and growing prevalence of chronic conditions, co-morbidities, and life threatening diseases; (7) Increased access inequity between EU MS. **DISCUSSION:** Cost-containment measures will increase under close supervision of parliaments. Fast development of electronic communication will allow online monitoring of drug utilisation. Adaptive licensing and limited evidence at time of launch will lead to generalization of coverage with evidence development. A more pragmatic approach in clinical trial designs should be considered to cope with concomitant development of companion diagnostics, segmentation of treated patients with targeted therapies; adaptive pathways should evolve from pilot to standard approach. Post-launch observational studies will become unavoidable to meet regulators and payers' expectations. Pan-European HTA coordination could lead to one single European HTA body assessing drugs prior to national HTA and pricing and reimbursement process. Managed entry agreements, ambulatory DRG, and bundled payments might become standard models. Integrated health services will expand, shifting payers role to health care providers. Differential pricing will address access inequity. **CONCLUSION:** Sustainability of healthcare systems will remain at the heart of drug funding decisions. Drug market access will evolve through extended collaborations and interactions between key stakeholders. Drug licensing, pricing and reimbursement decisions will be increasingly coordinated to enable fast patient access to innovative therapies. Real-world data will be central to switch from initial restricted access to progressive wider coverage.

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ADAPTIVE PATHWAYS MAY EXPAND THE GAP BETWEEN REGULATORS AND PAYERS

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BACKGROUND: Adaptive pathways (AP) are prospective planned approaches to regulation and coverage of drugs. Through iterative phases of evidence gathering, it aims to reduce uncertainties while balancing timely access for patients and level of available evidence. The concept assumes that all phases from development to clinical routine use through reimbursement are integrated. If AP did develop from regulatory perspective, many payers remain resistant. The aim of this research is to discuss payer's position on AP. **DISCUSSION:** Payers show an increasing resistance to uncertainty and their decisions are mainly driven by evidence robustness. Regulators are integrating foregone alternative treatment opportunities in decision making and increasingly registering drugs with limited evidence and larger benefit estimates. Time from development initiation to marketing authorization (MA) decreases overtime (compassionate use, accelerated assessment, conditional MA, MA under exceptional circumstances); On the opposite, time from MA to reimbursement expand with an increasing number of products denied reimbursement due to limited evidence. This gap between regulators and payers continues to increase and AP may widen this gap. While managed entry agreements were thought to help managing uncertainty, it happens, in most of the cases, to be used as disguised cost-containment tools. Only coverage with evidence development (CED) with escrow agreements remain an appropriate tool to address uncertainty, but is rarely used. The difficulty to reverse reimbursement decision makes payers very sensitive to uncertainty. AP is unlikely to address the payers concern unless they are directly involved in identifying risk, designing mitigation plan, and monitoring the uncertainty. **CONCLUSION:** AP may contribute to widen the gap between regulators and payers. Only CED with escrow agreement may be an appropriate tool to address payers' uncertainty. However, AP pilot projects with expected high benefit will exercise pressure on payers to issue reimbursement.

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TRENDS OF IMPLEMENTATION OF HTA IN KAZAKHSTAN

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Kazakhstan is an upper-middle-income country with per capita GDP of nearly US$13 thousand in 2013. Kazakh's public healthcare system – UNHS (Unified National Health System) – aims to deliver healthcare coverage to the whole population. The political desire of authorities to provide broader access to healthcare for its populations, along with the growing prevalence of non-communicable diseases (NCDs) such as cardiovascular disease, cancer and diabetes, are placing a strain not only on government budget but also on the healthcare infrastructure in Kazakhstan. Increasing life expectancy is giving rise to the greater burden associated with ageing populations, while governments struggle to balance growing costs with a need to expand healthcare provision to all. At the heart of any cost-containment strategy is a set of tools, ranging from complex risk-sharing schemes and health technology assessment (HTA) through to more simplistic mechanisms, such as prescribing controls and mandatory price cuts. Analysis of cost-management trends in Kazakhstan, relative with international experience, suggests a leaning towards less complex approaches. One reason for this is that before being able to even contemplate more sophisticated initiatives, governments must first address basic infrastructure needs. These include having sufficient doctors and clinics to diagnose and treat patients. There is growing appreciation that cost containment can only be effective when implemented in a systematic manner. Kazakhstan already have informal guidelines in place and are now considered «mature» markets in terms of HTA adoption. Despite the obvious challenges, some would argue that the time for HTA has arrived in Kazakhstan. Implemented correctly, it can play a role in the future of the region, not only as a key component of cost containment but also as a pivotal enabler for the efficient use of resources, as governments look to provide broader access to affordable healthcare for all.

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A CONCEPTUAL PAPER ON STEPS NEEDED TO REACH INTEGRATED HEALTHCARE SYSTEM IN EGYPT

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OBJECTIVES: This conceptual paper aims to build a roadmap to reach integrated healthcare (HC) system in Egypt for optimum efficiency and utilization of resources among the different insurance bodies. The roadmap will help fill in the gaps evolved from the fragmented system having 5 different types of insurance coverage. **METHODS:** Gap analysis between the desired integrated HC system that achieves; Equity, Solidarity and Free access to entire population, and the current situation of the HC system which was obtained from interviews and discussions with the HC payers and decision makers inside the public sector. **RESULTS:** A ten year roadmap was built with eight action steps that were identified to reach integrated HC system: 1- Task Force Committee: from inside and outside the public sectors, 2- Research and Data centre: responsible for Epidemiological and Pharmacoepidemiological studies, 3- Prioritization plan: prioritize coverage plan based on budget and strategic diseases burden , 4- Treatment Protocols Flowchart: ensuring unified treatment guidelines across different HC bodies 5-Unique Patient ID: thus all insured patients are traceable without double counts, 6- Health Information System: connecting all HC units for optimum resources utilization, 7- Primary Care Physicians Development Plan: continuous education programs for optimizing their utilization and freeing time to the over-utilized specialists, 8- Health Economics Unit: that will be the nucleus of establishing a Health Technology Assessment body responsible for economical strategic planning of the HC. **RECOMMENDATIONS:** Although some action steps were taken in some of the mentioned points however they were executed as separate initiatives inside the public sector; therefore it's of high importance that the taskforce committee takes the accountability of executing the project as a single mission, and make sure the executed action steps are utilized and integrated with the rest of action steps as per the roadmap timetable.

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HEALTH SYSTEM RESEARCH OPPORTUNITIES FOR ASSESSMENT OF THE NATIONAL HEALTH CARE SYSTEM

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OBJECTIVES: The health care system reforms, which in many countries, particularly in the Eastern Europe, started in the 1990s, affected Latvia as well. The directions of the reforms can be divided into two basic segments – health care system organisation and health care system financing. Within the framework of this research, the author evaluates the health system research opportunities to assess the efficiency of the health care system reform in Latvia. **METHODS:** To achieve the goal of the research, the methods of the theoretical research are used alongside the methods of empirical research. The methods of statistical analysis and methods of economic analysis are used for data processing and analysis. **RESULTS:** To perform the research, the author uses a three-level performance evaluation model based on macro-level evaluation, meso-level evaluation, and micro-level evaluation. The appropriate measures of the macro impact results, policy outcomes and performance outputs are defined to evaluate the effectiveness of the performed health care system reform. The author assumes that the macro impact results are specified for public health, the policy outcomes are determined for the health care, as well as the pharmacy, while the performance's outputs are representative for all areas. **CONCLUSIONS:** The general conclusions show, for example, that the economic efficiency of the reimbursement system is sufficient and at the same time there is a tendency to move towards technical efficiency rather than total economic efficiency (technical and allocative efficiency). The allocative efficiency in health economics is also associated with the market efficiency and effectiveness of the treatment process. However, the author notes that there are no perfect competition market conditions for health care products and services, so it is necessary to use alternative methods of economic analysis.